Karen S Ross

A FOLLOW-UP STUDY OF THE EFFECTS OF FAMILY ATTITUDES AND ACTIONS ON A GROUP OF TRAINEES AT A REHABILITATION CENTER FOR THE BLIND

Submitted in Partial Fulfillment of Requirements

for

the Degree of

Master of Science

at

Simmons College

Mrs. Barbara L. Singer

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ACKNOWLEDGMENTS

I should like to acknowledge my great debt to the Administrator and Staff of St. Paul's Rehabilitation Center for the Blind, for their great patience and help to me, in allowing me to participate in the training program, and in sharing with me so much of t heir valuable knowledge. Of particular help to me were Dr. Theodore Macklin, Staff Psychologist, and Mrs. Elizabeth Dowcett, Staff Social Worker, whose help, above and beyond the call of duty, were invaluable.

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CHAPTER I

INTRODUCTION

Much has been written about the care and problems of the blind over the centuries. Great strides have been made in their education during the past two hundred years, and a good deal of progressive legislation has been enacted, particularly in recent years. However, probably one of the greatest changes which has taken place has been in the rehabilitation of the adventitiously blinded person, due in large measure to the work done by the governments of the United States and Great Britain with the men blinded in World War II. The knowledge which was gained here, has been used since to help people of the general population who have suffered from disabilities such as those suffered by the servicemen.

Many ingenious and imaginative methods have been developed for teaching the adventitiously blinded to be more self-sufficient. However, not too much is known about what happens to these people after they leave the rehabilitation center equipped with a Hoover cane,[1] mobility techniques,

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[1]The Hoover cane is an elongated cane, usually made of aluminum, measured for each person depending on his height, used specifically for mobility. It is not the heavy white wooden cane carried by some blind people to signify their blindness. It is comparable to an antenna in pointing out obstacles to the user in walking.

and a knowledge of braille, and the many other skills so necessary to adult independent living. The question is whether they make use of this knowledge to its best advantage or whether they return home and put this knowledge, along with their canes, on the shelf. Howard Rusk points out that the final and crucial test of rehabilitation is not the "achievement in the rehabilitation training center, but the application of such training to successful living in the home community."[1]

Of particular interest to me has been the rehabilitation work done with adventitiously blinded adults at St. Paul's Rehabilitation Center in Newton, Massachusetts. This center was the first civilian outgrowth of the government centers. It was started by a priest who had worked at the government rehabilitation center in Avon, Connecticut.

Since 1954, thirty groups of between ten and sixteen men and women have undergone a thorough residential training program at St. Paul's, learning skills, many of which were developed or refined at the government centers. Rehabilitation personnel know from experience that the various techniques for teaching these skills are effective because they can see the successful learning process take place. However, beyond the matter of learning these skills is the consideration of whether or not they are used, and what factors determine the ultimate success or failure of the

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[1] McCoy, Georgia F., and Rusk, Howard A., An Evaluation of Rehabilitation (Rehabilitation Monograph No. 1. Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, 1953), p. 2.

rehabilitation process for the individual.

Little is known about what happens to these trainees after they leave St. Paul's and return to their families. Since they leave apparently able to perform to a greater or lesser degree the many skills learned, we wonder to what extent their use or disuse of these skills is influenced by their families' attitudes toward them and their blindness.

I found while spending some time at St. Paul's participating in the training program, that the trainee's progress could be markedly altered by a change in his relationship with the family. A visit from a wife, a call from a child, could completely hinder, or greatly enhance, temporarily, his ability to function in the program.

One staff worker told of a young man who had completed the program quite successfully. On the last day his father called for him, threw his cane in the trunk of the car and said, "Come on home now, son. That's the end of that nonsense!" Though this is certainly an extreme example, it demonstrates the importance of the interaction between the trainees and their families following training.

As the staff psychiatrist pointed out to the families at their Conference, the attitude of the family member is a combination of what they feel about blindness and what they felt about the trainee before he lost his sight. Were they, for example, particularly dependent on the trainee before he lost his sight, their role and attitude must of necessity change to a certain extent. This change may bring about many negative feelings and cause much strain, magnifying any

ambivalent feelings already present. These feelings may affect greatly the family's ability to help the trainee best use the skills gained at St. Paul's. How they have faced this problem, and how they are able to alter their attitude toward the trainee, his ability, his newly gained skills and independence, is one of our primary interests. My intent in this study is to find out what attitudes and actions of the families tend to foster or discourage the newly found independence of the trainee, bearing in mind of course, that there is no uniformity in the degree of competence of the various trainees at the end of the training period.

It is hoped that through a follow-up study of a group of trainees and their families something may be learned to add another facet to the knowledge of the rehabilitation process, so that perhaps future trainees and their families might be helped further to use this program to its fullest.

Setting

St. Paul's Rehabilitation Center is a non-sectarian civilian center for the rehabilitation and training of adventitiously blinded adults. It was established in 1954 under the auspices of the Catholic Guild for the Blind by Father Thomas J. Carroll who had worked with blinded servicemen of World War II, and felt a need for this type of service to civilians.

Located in Newton, Massachusetts, it is housed in two buildings of an old estate amidst beautiful gardens and sprawling lawns. There, 16 adventitiously blinded persons

enter together to live for a 16-week intensive residential training program.

The men and women live in large dormitory rooms on separate parts of the second floor of the carriage house. The first floor houses offices, classrooms, and an adjoining training kitchen. In the basement are a recreation room and a workshop outfitted with power tools used in the training. In a separate building is a small dining room where they eat all of their meals. The grounds as well as the neighborhood are used in the mobility training, and are in a sense their largest classroom.

The staff consisting of approximately thirty people, is made up of a psychiatrist, physician, nurse, psychologist, social worker as well as instructors in the various courses described below.

Blindness at the Center is approached as a multiple handicap so that the trainees are helped to cope with both the emotional and the physical problems which blindness involves.

Their spiritual needs are met by visiting clergymen of all faiths and transportation is available to them by volunteer drivers, to attend the church of their choice, if they wish.

They may have visitors at certain specified times and may spend some week ends at home, although they are encouraged to remain at St. Paul's as much as possible during the first few weeks. When they have won their "wings" (their ability to use a cane well enough to travel alone),

they are permitted to go alone to the nearby shopping center, in the evenings.

The referring agencies (usually the State Divisions of the Blind) are kept informed of the trainee's progress. His counsellor from his agency also visits him. Both because of the cost, and the intensity of the program, the referring agency looks upon the decision to recommend a candidate to St. Paul's as a very important one, particularly since it usually pays most or all of the cost. It is important to note that St. Paul's is not a vocational training center, but only serves as a rehabilitation center so that the vocational counsellor may then help the trainee to get vocational training and possible job placement.

Before coming to St. Paul's, the trainee and his family are interviewed by the Rehabilitation Field Representative to explain the program to them, and to help determine his suitability and his motivation for training.

Program

The program at St. Paul's is geared to the total rehabilitation of the trainee. Consequently he is helped not only in practical areas of techniques and sense training, but he is helped emotionally, and is also helped to understand the realistic vocational and financial problems facing him. It is a total program involving himself, his family and the community.

From 8:15 A.M. until 5:30 P.M., as well as some evenings, five and a half days a week, the trainees attend classes in

small groups of from one to six people. As a group they attend group therapy sessions, a class in attitudes and analysis (described below) and a weekly "gripe" session, where they may air their grievances about the program and instructors. They also have weekly individual counselling sessions with the staff social worker and occasional interviews as needed with the staff psychiatrist. There are visiting lecturers on vocational opportunities and on social security and legislative rights of the blind, so that they are helped in as many areas as may affect them specifically because of their blindness.

At the end of the twelfth week of training, a three day seminar is held for the families of the trainees in which they meet with the staff members and are told in some detail about the program. They have group sessions with the psychiatrist and psychologist and have individual counselling sessions available to them. In the sessions with the psychologist and psychiatrist they bring up many problems dealing with their blind relative and his problem as well as their own feelings about the trainee and about blindness itself.

Trainees are taught the Hoover cane technique and general skill in mobility,[1] so that by the end of the training program they should be able to go into downtown Boston alone by public transportation, go shopping, and return to St. Paul's unaided.

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[1] For a complete list of courses and descriptions of them, see Appendix.

Trained instructors help them to develop a sense of orientation so that they may enter a room and learn many things about it by themselves -- about its size, shape, contents, and general layout, and to retrain their remaining senses generally to take over some of the tasks previously handled visually.

In the various classes such as braille, fencing, sensory training, typing, housekeeping, and workshop, as well as at their meals, the trainees are helped to acquire the many skills necessary to help them to be more self-sufficient. They are taught to pour hot liquids, to sew, to make beds, cut their food, iron, and use power tools. Both men and women learn these skills, which are taught as much to help them gain self-confidence as for their practical use.

Upon entering the program, trainees are outfitted with occluders,[1] so that any remaining vision or light perception (and this varies greatly among the trainees from none to some travel vision) will be blocked out, to enable them to be trained making full use of their other senses. Many of the trainees will be losing their residual vision, so that it is important for them to receive training under these conditions.

Besides the training given to the group, the staff itself has weekly group psychotherapy sessions as a "necessary health measure" because of the highly charged problem

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[1]For a discussion of the implications of this to the trainee, see page 28.

of rehabilitation. They also have a week's evaluation of themselves and the program, the week after each group leaves.

Method

A. Sample

The group studied was Group XXX which attended St. Paul's Rehabilitation Center from July 9, 1962 to October 24, 1962. The total group was 15. For practical reasons the sample was limited to the ten members of this group living in Massachusetts, the geographic location being the only criterion used for singling out this group. Of the ten selected, two did not complete the program, but it was decided to include them in the sample.

B. Data Collection

The data was collected in personal interviews conducted three months after the end of the training program. This time limit was chosen to give the trainee an opportunity to adjust to home and community and attempt to find a place for himself hopefully either in work or further training. Had more time elapsed too many additional and extraneous factors might have been considered to cloud the effect of the St. Paul's training.

Eight of the trainees were interviewed personally with at least one family member. Two of the trainees refused to be interviewed so that the information on follow-up in these two cases was obtained through an interview with his counsellor from the Division of the Blind.

Preliminary data containing background information was

taken from records at St. Paul's as well as from interviews with the staff social worker. Staff assessments following their training were obtained from records and interviews with the staff.

C. Background Information

To gain information for this study, I went through many hours of classes with the trainees wearing occluders,[1] talking to them, learning the skills along with them, trying to get some minute idea of the day to day problems faced by them in simple automatic tasks of daily living such as lighting a cigarette, tying a shoe, finding an empty chair to sit in, or sewing a button.

I also attended the Family Conference of this group, and St. Paul Staff meetings, as well as their annual professional seminar held for workers in the general field of work with the blind.

Limitations of Study

1. This is a preliminary exploratory study of one group of trainees out of the thirty groups who had attended St. Paul's up to the time of the study.

2. The sample was small because of the necessity of setting geographic limitations, and there is a strong

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[1] It is a strict rule at St. Paul's that anyone attending classes or participating in the program in any way (except the instructors) must wear occluders (a) so that the trainees will feel more comfortable during the learning process, and (b) so that the observer may gain some clearer notion of the process itself. At regular intervals during the training period all staff members must be occluded for two consecutive periods and travel to the different periods occluded.

possibility that the results would have been different had it been feasible to have the study include all of the trainees in Group XXX, the particular group studied.

3. Since bad weather was the reason given for limited activity by a number of the trainees, having a control group at a different time would certainly have given a better picture.

4. Many staff changes took place in the middle of the training program of this particular group, so that the continuity of training and of atmosphere was interfered with.

5. Since background information used in this study was not gathered for research purposes, some data which would have been helpful and desirable, was missing.

CHAPTER II

LITERATURE

The history of the care of the blind as told by Farrell[1] and by Chevigny,[2] goes back to about the sixteenth century at the time of Milton, when Vives and Fagnani, in Spain and Italy respectively, both felt that something should be done to help the blind stop begging and do something more productive. This history has passed through three broad phases "mendicancy, asylum, and integration, or permission for the blind to take a position in regular society."[3]

The first great change took place at the time of the American and French revolutions when, as Chevigny points out,[4] people imbued with the revolutionary spirit, politically and socially, made the emergence of the blind possible. It was out of this spirit that Louis Braille, the man most responsible for the dot system of writing used by the blind, and Samuel Gridley Howe, the first head of Perkins School for the Blind, emerged.

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[1] Gabriel Farrell, The Story of Blindness (Cambridge: Harvard University Press, 1956).

[2] Hector Chevigny, and Sydell Braverman, Adjustment of the Blind (New Haven: Yale University Press, 1950).

[3] Ibid., p. 100.

[4] Ibid., p. 140.

Another man who was responsible for much revolutionary thinking in the field was Thomas Cutsforth.[1] His writing was outstanding, though in reading it now, one might compare it with a re-reading in 1962 of Gompers' writing on abolishing sweat shops, and the need for labor unions. Gutsforth had strong feelings about such things as puritan attitudes concerning separation of the sexes in institutions, and about the separate institutions themselves. It is now fairly well accepted in the field that children who are able to be integrated in regular schools are far better off educationally, emotionally, and socially. In all of the current reading there is a great emphasis on the importance of integrating the blind in society, of having them treated as people, not as blind people. While Cutsforth concerns himself more with the problem of the congenitally blind, his feelings in this area are shared by Father Carroll,[2] Hector Chevigny,[3] and others concerned with the rehabilitation of the adventitiously blind.

Interest in the adventitiously blind has greatly increased since World War II. It is notable that it took another political upheaval to bring about this great breakthrough in the rehabilitation work with the blind. Work in this area was started in the United States by the Veterans'

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[1]Thomas D. Cutsforth, The Blind in School and Society (New York: American Foundation for the Blind, 1958).

[2]Reverend Thomas J. Carroll, Blindness (Toronto: Little, Brown & Co., 1962).

[3]Chevigny and Braverman, op. cit.

Administration at a center for newly blinded veterans in Avon, Connecticut. It was here, according to Edward Fitting[1] that the first real work in mobility was done, and much of the current knowledge about rehabilitation in general developed. Mr. Fitting gives a brief history of this, starting with the center at St. Dunstan's in England.[2]

Father Carroll in his book Blindness[3] covers most of the problems connected with the rehabilitation of the adventitiously blinded, discussing the twenty losses he feels are suffered by the newly blinded person, how devastating they are, and what can be done about them. The problem of the congenitally blind in terms of training are quite different from those of people who have had sight, and Father Carroll in his work and writing has concentrated on this latter group.

Father Carroll states that "Loss of sight is a dying."[4] He then goes on to elaborate on the ideas of Drs. Cholden[5] and Blank,[6] who feel that loss of sight is most comparable to the loss of a loved one. The reaction experienced closely

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[1]Edward A. Fitting, Evaluation of Adjustment to Blindness (Research Publication No. 2. New York: American Foundation for the Blind).

[2]Ibid., p. 10.

[3]Carroll, op. cit.

[4]Ibid., p. 11.

[5]Louis Cholden. A Psychiatrist Looks at Blindness. (New York: American Foundation for the Blind, 1958).

[6]Robert Blank, "Psychoanalysis and Blindness," Psychoanalytic Quarterly, XXVI (1957).

resembles that described by Lindemann in his article on grief reactions.[1] First is a period of shock, followed by a time of grief when the blind person mourns over the lost object--his eyes. After this comes a time of depression which the blind person should be permitted to go through, for, as Dr. Cholden states, "Depression is a necessary precursor to learning, which is no necessary to the newly blinded person."[2]

One of the essential tasks of the rehabilitation center is to help the trainee through these periods, and to recognize the importance of this grief in connection with his ability to learn. It is important then, in the rehabilitation process, to give the blind person not merely technical training but also the psychological and social help needed to implement this training.

The writings on rehabilitation point up with great similarity that the final and crucial test of rehabilitation is not the achievement in the rehabilitation center, but the application of such training to successful living in the home community."[3]

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[1]Erich Lindemann, "Symptomatology and Management of Acute Grief Reactions," Journal of Psychiatry, (September, 1944).

[2]Louis Cholden, "A Psychiatrist Looks at Blindness," (New York: American Foundation for the Blind, 1958), p. 81.

[3]Georgia F. McCoy and Howard Rusk, An Evaluation of Rehabilitation. Rehabilitation Monograph No. 1 (Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, 1953), p. 10.

As is pointed out by Curtin[1] and Carroll[2] the families play a vital role in the areas of dependence and independence. The families may be overprotective (1) to satisfy a need of their own to dominate the person; or (2) they may have a very hostile reaction "involving indifference, resentment, rejection, or criticism."[3] Dr. Cholden points out that if the family, for whatever reasons, cannot allow the trainee to be independent, rehabilitation will be difficult. Likewise, if the trainee should find blindness a socially acceptable way of being dependent, then rehabilitation will also be difficult.

Underlying the family problem is the degree to which the family is able to treat the trainee as a normal healthy human being who has lost his sight--and not a scapegoat for myriad feelings of anger, insecurity, guilt, etc. Both Carroll and Chevigny point out the importance of recognizing that both the blind person and his family approach blindness with fixed ideas about it which they have held for many years. They have the same stereotypes as other people in society--the picture of the blind beggar, the blind genius, the extra senses of the blind, etc. Both the blind person and his family must alter these notions if a maximum degree of rehabilitation is to be effected.

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[1]George Curtin, "Mobility: Social and Psychological Implications," The New Outlook, (January, 1962), p. 16.

[2]Op. cit.

[3]Curtin, op. cit., p. 16.

As Mr. Finestone[1] and Father Carroll[2] point out, the family plays an essential role in the rehabilitation of the blind. Consequently, concern for the parents and other sighted relatives "is important if the blind family member is to be helped."[3]

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[1]Samuel Finestone (ed.), "The Family in the Rehabilitation of Blind Persons," Social Casework and Blindness, (Research Center, New York School of Social Work, Columbia University, New York: American Foundation for the Blind, 1960), pp. 125-133.

[2]Carroll, op. cit.

[3]Ibid., p. 131.

CHAPTER III

DESCRIPTION OF TRAINEES

TABLE 1

AGE AND SEX OF TRAINEES

Age	Sex		Total
	M	F	
25-30	2	1	3
44-51	6*		6
Over 65		1	1
Total	8	2	10

*Two of these trainees left the program after completing one third of it.

It is interesting to note that the majority of trainees in the sample are males between the ages of 44-51, an age when men tend to be at their most productive and generally settled in what they are doing. Retraining men of this age is necessarily more difficult than retraining younger men.

It is also a higher age level than the average of 41 years, taken of the 203 trainees who were in groups II-XXIV at St. Paul's.[1]

Also of interest is that the population at St. Paul's

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[1]Bishop, op. cit., p. 6.

has generally been a predominantly male one, partly because there is limited dormitory space available for women. There is no significant difference in the ratio of men to women in this group, from the groups studied by Bishop. The ratio in that study was found to be seven men to three women.[1]

Family Configuration

There were six trainees who were married, all of whom were male. Of the six, one was living alone with his wife. (Their children were married and living elsewhere.) Four were living with their wives and children. One was living with his wife and her parents.

There were three trainees who were single. Two were male, one was female. They were all living at home with their parents. Each one also had one single brother living at home with them.

There was one trainee who is a widow and lives alone, although she has two unmarried sisters who live close by.

All of the trainees live within a family group who are involved with them in their daily living. The dynamics of these family situations will be discussed in a later part of the study.

Although no one in the group shown in Table 2 had any higher education, St. Paul's frequently has people who have had further education than this.

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[1] Ibid., p. 7.

TABLE 2

EDUCATION OF TRAINEES

High School graduates	5
Attended High School 5 years, but did not graduate	1
Completed Grade 9	3
Completed Grade 6	1
Total	10

TABLE 3

RELIGION OF TRAINEES

Catholic	6
Protestant	3
Jewish	1
Total	10

Since people are referred largely from the State Division of the Blind, and since St. Paul's is the only center of its kind in the area, it is probably accidental that there is a preponderance of Catholics in this group.

TABLE 4

OCCUPATION OF TRAINEES

Factory workers	2
Clerical workers	2
Crane operator	1
House Painter	1
Housewife	1
Mechanic	1
Plumber	1
Storekeeper	1
Total	10

It is interesting to note that in this group there were no professional people. Also with the exception of the housewife, it is highly unlikely that any of them could return, even with training, to the job they held before loss of sight, because of the type of jobs they had held. To rehabilitate these trainees vocationally would necessarily involve training in work unfamiliar to them, at least to a limited extent.

Stability of Employment

There were three trainees who have had many unrelated jobs in the past. Their work history seemed more in the nature of instability than in the steady furthering of their careers.

The other seven trainees happened to have worked at the same or similar jobs during their employable years.

Their years since last employment, at time of entering St. Paul's varied from fourteen years for one trainee to two months for another. This will be described in detail under the section on trainees' vocational adjustment.

Cause of Blindness

TABLE 5

DIAGNOSIS OF EYE DIFFICULTY

Diabetes	5	
Detached Retina	3	(One of these is also diabetic)
Glaucoma and Cataracts	1	
Retinitis Pigmentosa	1	
High Myopia	1	
Total	11	

According to a study done at St. Paul's[1] 39% of trainees are diabetic; 11% have glaucoma; 8% have detached retina; and 8% retinitis pigmentosa.

The largest single cause of blindness is diabetes. Until recently the diabetes was thought to be the cause. Recently however, there has been speculation that the insulin taken for the diabetes may be the cause of blindness, rather than the diabetes itself. Whatever the outcome of this speculation, the health problem of the diabetic must certainly come into consideration in any discussion about the blind diabetic. (One trainee stated that his diabetes was of more trouble and concern to him than his blindness.)

Diabetes can affect the eyes in three ways which cause loss of vision--hemorrhages caused by the weakened capillaries in diabetics; an inflammatory reaction of the retina associated with the toxic substances occurring in diabetics; and early degenerative changes in the arteries known as diabetic arteriosclerosis.

The same factors which produce changes in the eye may also produce changes in the kidney, the circulation, and subsequently the heart. A common complication of diabetes affects the peripheral nerves which have to do with sensations in the hands and feet. This is an effect which may be periodic, depending on the physical and emotional well-being of the person at a particular time. Consequently the sense of touch of some diabetics may sometimes be affected making

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[1]Bishop, op. cit., p. 11.

braille difficult to read. In others the legs and feet are affected causing problems in mobility.

The physical effects therefore, affect not only rehabilitation, but the general outlook of the blind diabetic. Although all blind diabetics are not affected to the same degree by their diabetes, it is an added and vital point to consider in evaluating their progress.

In this sample, one diabetic has been severely handicapped by physical complications due to diabetes. It affected his ability in the various courses at St. Paul's, and though a well-motivated trainee, he has been unable for most of the time since the end of training, to use the skills he learned.

One diabetic has had difficulties with fatigue and contractures of the hands caused by poor circulation, and another with poor circulation in the legs, affecting his mobility. The other two diabetic trainees were not affected in their functioning in any way except for vision. (One of these two trainees has a brother living at home who is also diabetic, but has had no known visual difficulty.)

The trainee with retinitis pigmentosa (a chronic and progressive retinal inflammation causing streaks of pgiment in the inner retinal layer) has a sister blind from the same cause.

The trainee with high myopia (a severe degree of nearsightedness), has two sisters with whom she is quite close, who have this condition in a less severe form.

One trainee with detached retinae has been operated on ten times unsuccessfully (the last time being two months after leaving St. Paul's) for correction of this condition. The other trainees with detached retinae have not been operated on to our knowledge.

TABLE 6

RESIDUAL VISION

3/200 or better in both eyes	2
Light perception one eye (3/200 in other eye)	4
Light perception both eyes	4

Light perception is the ability to recognize that there is light.

Vision of 3/200 is the ability to see at three feet what should be seen at two hundred feet, i.e., seeing the large E on the eye chart at three feet.

As can be seen from the above, most of the trainees in this sample have at least some very slight degree of sight. Consequently, for purposes of rehabilitation all trainees in the sample wore optical occluders to cut out any remaining vision. These people for the most part try so hard to use whatever remaining sight they do have that they are unable to concentrate on retraining their remaining senses without being occluded.[1] Being occluded presents problems to the trainee which should be handled with them. Some people at St. Paul's feel that the trainee should be shown the occluders and allowed to try them on at the time of their interview for

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[1] Carroll, op. cit., p. 311.

St. Paul's, so that they will have some notion of what they are facing. They are told that they will wear them, but this is rather different. It seems that unconsciously the trainee feels in coming to a rehabilitation center such as this, that somehow his vision will be restored. They cling desperately to their remaining vision because of the often realistic fear that this vision too will be lost. They then come to St. Paul's where instead of their unconscious wish coming true, their worst fears are in a sense realized when they are occluded. Many of the trainees resist them to some degree, find them difficult to wear, and often tend to "cheat" when they feel they are not being noticed, or are in a particularly difficult situation. However, despite this problem, they are essential if the trainee is to derive maximum benefit from the training.

The problem of partial sightedness, which the trainees in this sample face to a greater or lesser degree, is a problem with most trainees at St. Paul's. Only thirty-eight trainees out of the 203 studied at St. Paul's[1] had no vision at all, so that this is a real consideration in understanding the trainees' reactions to learning some of the skills, and the families' in adapting to this, since there is no clear demarcation between seeing and not seeing.

> To those around him he appears able to see more at one time than another, to claim more sight than he has in order to bluff the neighbors, or less sight in order to obtain sympathy. His state of health, weather, and light conditions all make a difference in what and how

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[1]Bishop, op. cit., Appendix 1, p. 6.

> much he can see at any given moment . . . . Thus he suffers the emotional disturbances of a severe visual handicap which everyone around him knows is labeled "blindness," plus those added by the knowledge that he isn't really blind (but fears he may become so . . .) and yet is being treated as if he were (and feels deeply guilty at accepting such treatment).[1]

There is also a resentment on the part of some of the totally blind toward the partially sighted because they have so much vision.

It is important then to have a fuller understanding of the reactions of some of the more sighted trainees to the use of braille, mobility, and some of the other skill courses particularly. It helps to give a clearer understanding, too, of the attitudes of the families. For example, the sister of one trainee takes her marketing. Since the trainee is able to find the shopping basket herself, her sister becomes angry when she asks for help locating the food or walking around the market, insisting that she could manage by herself if she really wanted to.

Duration of Visual Difficulty

Four trainees have had visual difficulty for from one to four years. Six have had visual difficulty of long duration (from eight to twenty-five years) with recent worsening.

The duration of blindness may affect the trainee's ability to visualize, which is a basis for much of the training at St. Paul's. Training of the senses is done partly with keeping in the trainee's mind a picture of a tree, a chair, a room, so that he can continue to use this

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[1]Carroll, op. cit., p. 312.

as a helpful guide in keeping his sensory activities visually oriented. In this way, as in some others, training of the adventitiously blinded is so different from the congenitally blind. The congenitally blind have never seen and cannot visualize things as someone who has sight. Someone who has seen should be encouraged to keep us these visual images to increase and enhance the use of his remaining senses.

Trainees' Attitudes About Sight Loss

Father Carroll discussed in detail the twenty losses suffered by the adventitiously blinded person.[1] These vary in intensity with different people by the very nature of the individual personality and his way of life. Regardless of which of the losses are more deeply felt, all of these people must inevitably, in some form or other, experience a grief reaction to these losses and experience the various stages of shock, depression, and hopefully readjustment. The ability of the trainee to use the program at St. Paul's to its fullest depends to a large extent on how they see their blindness and at what stage they are going through when going to St. Paul's. How honest they are both with themselves and others about these feelings will affect their ability to face the reality of this difficult adjustment. Hand in hand with this goes their perception of their prognosis.

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[1] Carroll, op. cit., pp. 14-79.

Feelings About Prognosis

Six of the trainees stated that they did not expect to regain their sight. All of these expressed the hope that they would be able to retain what sight they had. One of these has had an operation, (so far unsuccessful) since training, and he gave me the impression that he is still clinging to the hope that his vision will return. Another of this group, although stating that he does not expect his vision to improve, has devised a double pair of glasses (since leaving St. Paul's) with which he says he can now watch television. He, too, gave me the impression that he still believes in a miracle, and denies the reality of the situation.

Two stated that they hoped they would regain some of their sight, although there was no basis for this feeling according to medical reports. At time of follow-up, both of these trainees had unfortunately suffered further sight loss.

One trainee does not accept that his sight will get worse, although he did express the feeling upon entering St. Paul's, that he might not be alive in six months. At time of follow-up, his sight had not deteriorated at all and he felt then that he was in excellent physical condition.

One trainee fears that her sight will get worse. She is the oldest of the trainees, and her fears are realistic as far as her vision is concerned, and understandable, considering the general feelings and concerns of a person of her age.

It is interesting to note that four of the five

trainees who are diabetic expressed some hope about regaining sight. The fifth who did not, feels that his diabetes is more of a problem than his sight loss.

Feelings About Loss

Three of the trainees expressed feelings of depression about sight loss. Two of them are fathers and felt depressed about loss of ability to provide for their families, and the effect blindness had had on their children.

Four expressed feelings of anger and bitterness over the loss; one of these related his anger to the doctors who did not tell him that he was going to be blind.[1] Another felt that he was robbed of his birthright and the other two felt somehow that their families were to blame for pointing up the loss either in their treatment of him, or in their insistence that he come to St. Paul's.

One trainee said that he was not discouraged about the sight loss, but appeared very depressed throughout the program.

One trainee expressed no feeling about the sight loss at all, and it was difficult to separate her feelings about her general life situation from those feelings pertaining to her blindness.

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[1] Cholden has an interesting discussion about attitudes of ophthalmologists and their feelings about telling patients about the prognosis of their visual problems. He feels that they are often at fault in "leading them on" because the physicians are unable to admit their own inability to help the condition. They thereby intensify the problem for the patient, in keeping him from facing the blindness in a healthier way. Louis Cholden, op. cit.

Following training, two of the trainees said that they had felt sorry for themselves at first, but being at St. Paul's made them realize how well off they were compared to other trainees, which, in fact, they were.

In examining the trainees' ideas about the prognosis of their vision, only one expressed any feeling that his eyesight would be worse. The rest either hoped it would get better or become no worse.

Eight of the trainees expressed general depression, anger, or bitterness about the loss, and two of them felt their families were in some way responsible for the situation being as bad as it was, and were angry that they had made them come to St. Paul's.

CHAPTER IV

FAMILY ATTITUDES TO TRAINEE

Having examined in the last chapter the feelings of the trainee about his sight loss both from the medical and psychological point of view, we shall now look at the family's attitudes toward the trainee.

In examining the family's attitudes toward the trainee, it is important to bear in mind that the family's attitudes are a combination of their attitudes toward the trainee before the onset of blindness and their own ideas about blindness itself,[1] and how the family views this affects the trainee.

In this section we shall examine how the family acts and feels toward the trainee primarily from the point of view of his attitudes toward independence, since this is essentially what we are studying.

At time of entering St. Paul's the families of four of the trainees allowed them to do virtually nothing for themselves, beyond a bare minimum of personal care. Three of these trainees were married and had good relationships with their wives, although one trainee was having some marital strain directly related to loss of vision. The wife of

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[1]Introduction, p. .

another trainee was overprotective, and also expressed shame about his blindness, feeling that they could not appear in public. She said that she always thinks of blindness as a "blind man with a tin cup." The unmarried trainee in this category has a brother living at home who is alcoholic and who was recently released from a mental hospital. He also has a sister who is blind from retinitis pigmentosa--his diagnosis also. His mother has treated him like a young child and given in to his every whim, apparently to some extent because of her feelings of guilt over his blindness.

One trainee, single, lives with his parents and brother. His mother was overprotective, but because of his remaining vision he had some independence. His brother is diabetic as is trainee. The trainee has a very good relationship with his family, although his parents also are rather overprotective of him. There is diabetes on his mother's side of the family and she has expressed some feelings of guilt about trainee's blindness. His sister who lives nearby has had a very positive attitude toward having him gain some degree of independence. He was engaged to be married and this engagement was broken when he began to lose his sight. His ensuing depression caused by this double loss was noted by this sister and she was, as will be seen in the next section, the motivating force behind his going to St. Paul's.

The families of two trainees had very positive attitudes toward their independence. Without undue hostility they urged these trainees to be independent and to participate in discipline of the children. The wife of one

frequently turned off her hearing aid so that he would have to manage the children himself. The other trainee is a widow whose children helped her settle in a small apartment of her own, helped her to buy the furniture, but insisted that she choose the colors and style of furnishings. Her two sisters live nearby and although trainee feels they are often angry at her, they are generally kind and helpful. These sisters also have some visual difficulty of a similar nature to trainee's, though not so severe, and their feelings of concern about their own future are probably involved in their feelings toward trainee.

The other three trainees, two married and one single, have long-standing family difficulties pre-dating visual loss. One of these two married trainees is psychotic with a history of alcoholism pre-dating sight loss, although he is not now alcoholic. His children insist that he wear glasses telling him that he does not look well without them. His wife and children go bowling, to the movies, and engage in other activities in which he does not participate at all. His family regards him as a rather painful burden.

The wife of the other married trainee has made great effort to keep him from the children, who range in age from 3-13. She expressed great anger about his blindness, which was the "last straw" in a very delicate marital situation.

The single woman trainee in this group lives with her parents and brother. Her mother who is alcoholic and her father who has been unemployed for many months apparently dominate her completely, take her monthly check from the

Division of the Blind, and seem to capitalize on her blindness. At time of entering St. Paul's they would not allow her to use a cane because they were ashamed to have her seen with one.

At time of follow-up, of the four families who had cared for the trainee to a very great extent before St. Paul's, two showed marked change. The wife of the trainee who had been under some strain since visual loss, felt that the separation had made it possible for her to adjust to his sight loss. She has for the first time, encouraged his independence in many ways.

The mother of the unmarried male trainee feels that now that he has had training, he can be independent and she urges him to be. She now feels that he should be married so that she can have some peace and freedom.

There has been no change in the other two families of this overprotective group. One trainee has been so ill that it has been necessary for his wife to care for him.

The family of the unmarried diabetic trainee with a somewhat overprotective attitude now feels that he can be more independent. His mother feels that the separation has made her able to allow him this independence.

The two families who had positive attitudes toward independence of the trainees before St. Paul's have continued this positive attitude.

There was little change at the time of follow-up in the attitudes toward the trainees of the three families where there had been discord. They did encourage their independence but in a very hostile way.

In general two families who had overprotective attitudes before St. Paul's were able to allow trainee more independence; one remained unchanged, and one trainee was sick, so that we cannot determine family attitude change in this case. The one who had been somewhat overprotective improved. The two who had positive attitudes toward independence kept these attitudes. In the three families where there had been discord, there was a hostile use of urging independence.

The only attitude which was not oritented toward allowing independence, and remained unchanged after St. Paul's, was in the family which did not want the trainee to come to St. Paul's and where the trainee left. It was my impression that in the recognition that the trainees were able to learn something and to be separated from the families without ill effects that the families felt a permission (particularly in the overprotective group) to encourage independence.

One interesting fact is that in all cases where children were involved, at least one child in each family commented that the trainee was easier to live with, and regardless of mothers' attitudes, they felt that their father was "more of a person." One 15-year old expressed it simply. "He's just more fun to live with."

to come, although trainee's sister urged him to come so that he would be able to gain some degree of independence. This trainee is one of the two who did not complete the program.

Seven families were very interested in the trainee coming to St. Paul's; two families were mildly interested; and one family did not want the trainee to come. At time of follow-up, the six of those very interested, who were available, as well as the two who were mildly interested, had an essentially positive appreciation for the program, in spite of the fact that some of their previous hopes had not been fully realized. The family which did not want the trainee to come, continued to have this negative attitude to St. Paul's.

It is of interest to examine the motives of the families for wanting the trainee to come. Six of the families were supportive and helpful toward the trainee and primarily interested in having St. Paul's help the trainee be more independent. Three of the families were hostile to the trainee and were primarily interested in having him out of the house.

In general, despite mixed motivations for wanting the trainee to come and a mild undercurrent of dissatisfaction with one phase or another of the training, eight of the families were satisfied with the program. The attitude of one family was unknown, and the family who had not wanted the trainee to come was pleased that he left.

Trainees Attitudes to St. Paul's

Just as the attitudes of the families varied about the trainee coming to St. Paul's, so naturally did the attitudes and motivations of the trainees themselves vary.

TABLE 7

TRAINEES ATTITUDE TO ST. PAUL'S

Attitude toward Coming	Number	Attitude at Follow-up Positive	Improved
Positive	6	5*	
Mildly Interested	2		2
Negative	2		2
TOTAL	10	5	4

*One trainee was unavailable at follow-up because of illness.

It is interesting to note that the attitudes of trainees who had been mildly interested or negative, improved and those who were positive did not change their attitudes.

The motivations of those who came, varied. With the exception of two trainees, they all stated that they hoped to gain something in the area of skills. These two trainees were the ones categorized as negative. One felt he had too much vision and did not need training; one was not interested in gaining independence. He said he was content as long as he had a "mother and an automatic washing machine" to take care of his needs.

Those trainees who were positively motivated had other reasons for wanting to come besides learning skills. Four of them were motivated to come largely because they were

anxious to be separated from their families. They felt that the separation would be good for them, because the situation at home was tense--and they wanted a change to "get away for a while." The trainees with children living in the home stated as part of their reason for coming, a desire to manage better for the sake of their children.

In summary, the trainees had come with different motivations, some primarily to learn for whatever reason, some to be separated from their families. All who had wanted the separation felt they had gained by it. Some trainees stated in one way or another that they were promised more than they got. This reservation often seemed to me to be related to feelings that somehow by going to St. Paul's they would regain their sight.

Regardless of their motivations for coming, or their feelings about the program, there were certain comments which most of them had about the program. All trainees from whom follow-up information was obtained felt that the change of staff during their training period, made their stay difficult. They also felt that an attempt should be made (1) to make the group a more homogeneous one in point of age, interest, etc. and (2) to give them more opportunities for recreational activities. They also felt they were treated more like school children than adults. They were all of the opinion that there should not be such varying degrees of residual vision among the trainees in a particular group. Realistically this would be most difficult.

This comment seemed more an expression of the problem of partial sightedness, which was discussed earlier.[1]

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[1] P.

CHAPTER VI

ADJUSTMENT OF TRAINEE

Skills

We have discussed the attitudes of the trainee and his family toward coming to St. Paul's. It is now important to evaluate the skills and use of them, because this is the main part of the training at St. Paul's, and it is the use made of these skills which we hope to use as a barometer of adjustment and independence.

Use of Skills by Trainee[1]

TABLE 8

STAFF RATING OF TRAINEES AT END OF TRAINING

Rating	Skills			Techniques of Daily Living
	Braille	Typing	Mobility*	
Good	2	4	5	4
Fair	5	5	3	3
Poor	3	1		3

*Mobility instructor changed after two trainees left program, so there was no rating for them.

Although only three did poorly in braille, no one uses it. Although only one did poorly in typing, only three use

[1]For a complete list of courses and definitions, see Appendix B.

it. No one did poorly in mobility, and many use it. Six were rated either fair or poor in techniques of daily living, yet eight of the trainees make some use of it.

TABLE 9

USE OF SKILLS

Number	Skills					
No. using at admission	Braille	Typing	Mobility			Techniques of Daily Living
No. using skills at admission	3	3	2 (Limited)			3
No. using skills at follow-up	Often	Seldom	Never			
	0	3	7	2	1	8

There is no major relationship apparent between how well the trainees did in the courses at St. Paul's and the use which they made of it.

Use of Skills

Braille

Following training, none of the trainees used braille, at all, with the exception of one trainee (who had not had braille prior to St. Paul's) who is now studying braille with a home teacher. (This trainee had done well in it during training, but left the program after six weeks.)

Two of the trainees do not use braille because of difficulties in touch--one from diabetes,[1] one from arthritis. The other trainees said that they had no use for it. One

[1]The other diabetic trainees did not mention sensory difficulty as a reason for not using it.

trainee said that he used braille to label his medicine bottles. However, I observed the bottles which were unlabeled.

There is some speculation about their resistance to braille. It is possible that they genuinely have no use for it for reading purposes, particularly since there are talking books available, and since none of them are students. However, they are taught to make braille labels for easy marking of many small items including clothing, medicines, toilet articles, and food items, so that they might find them without asking for help. It was found at follow-up that they do not use these labels. Whether they really prefer to retain this dependence on their family members, or whether braille is the skill most associated in their minds with blindness, and for this reason they resist it, we cannot say.

For the diabetic trainee is the added question of their neuropathy and how much this might interfere with their ability to use it. However, as mentioned above, it was not given as a reason by most of them.

Typing

Only three trainees use their typing following training. These three did well during training and two of them used it a great deal before coming to St. Paul's.

Two other trainees would like to type if a typewriter were available to them.

Mobility

Nine of the trainees use mobility. The one who does not use it at all, left training early and has not been

encouraged by his wife to take further lessons, as has the other trainee who left early. Of the nine, two use it seldom--one because he has enough residual vision to travel during the day without a cane; the other is mentally ill and feels he would be watched constantly by sighted people when out with it.

It is interesting to note that three of the trainees who refused to use the cane before coming to St. Paul's, because of some embarrassment, now use it daily.

Neither their previous knowledge of mobility nor the rating of their skills at St. Paul's, appeared to have any relation to the trainees' use of mobility at time of follow-up. In fact, two trainees who were considered by the staff to be able to make only limited use of their mobility, use it to a great extent.

It would seem then that the push to travel freely, supersedes (1) their embarrassment about the cane; and (2) their facility with it. This skill was the one most readily referred to by the trainees in a positive way.

Techniques of Daily Living

Eight of the trainees stated at follow-up that they made some use of these techniques--although two are not permitted by family members, to pour coffee--this being one of the skills learned.

Of the two who do not use the skills, one trainee uses none, because his wife will not permit him to. (This trainee left early in the program.) The other trainee uses one or two skills rarely, and only when "she feels in the

mood." The general feeling of the trainees was that although there is no uniformity in the types of skills they find of use to themselves, the course itself contributed greatly to their feeling of independence. Except in two cases, this was an area of improvement which pleased the families greatly.

Other Skills

In the areas of Housekeeping and Shop little information was available from either the rating sheets of the instructors, or the follow-up interviews. However, the following information is of interest.

Six of the trainees made no mention of housekeeping skills used. Of the four who did, one is a housewife who came to St. Paul's essentially to become a more independent homemaker. One trainee manages many of the household chores because his wife works. However, he and his wife have made what is to them a satisfactory demarcation between what is appropriate for a man to do, and what is strictly "woman's work." In this way he is not wholly permitted to take over the feminine role while his wife works. One trainee helps his wife with the dishes occasionally, and the other will use some housekeeping skills when visiting a friend who is a fellow trainee. He does not use these skills at home, however.

Three trainees who had used power tools before coming to St. Paul's were helped to improve the facility and safety with which they were able to use them.

There is not sufficient information available in other

skill areas to comment on their use by the trainees either before or after St. Paul's.

Summary of Skills

In general, mobility and techniques of daily living were the two areas in which trainees showed the most gain. Eight of them also stated that in some respects sensory training helped them. The more the trainees extended themselves into the community, and out of the house, the more these skills were used. One wonders if benefits of all skills learned may be difficult to assess completely because some gains are more diffuse and hard to define. For example, in such courses as braille and shop, some of the benefit may have to do with a feeling of mastery completely apart from the actual usefulness of the skill itself.

Responsibility of Trainee in Family

We have now examined the use of skills, tools which are vitally related to functioning both within the family and in the community--socially and vocationally. These are only part of a larger picture which we shall now examine.

Vocational

At time of entering St. Paul's, the following is the time lapse since trainee's last employment.

TABLE 10

TIME LAPSE SINCE LAST EMPLOYMENT

14 years	1
7 years	1
2 years	3
1 year	2
2-6 months	2
Continually active as housewife	1
Total	10

Cause of unemployment: Poor vision in all cases.

At time of follow-up three trainees were involved in some type of vocational training. The trainee who had not worked for fourteen years was attending business school with the intent of doing some type of office work--a realistic goal for him. One of the trainees who had not worked for two years is receiving on-the-job training and receiving a weekly salary, as a dark-room technician for a radiologist. The trainee who had left work only two months before entering St. Paul's was completing a vocational rehabilitation training program at Morgan Memorial. At time of follow-up he was quite depressed despite the tremendous achievement in completing these two programs (the one at St. Paul's and the one at Morgan Memorial). It would seem to be a possibility that more time should elapse between cessation of employment as a sighted person and preparation for work as a handicapped employee. In the case of this trainee there had been some question throughout his training whether he had reached the stage in facing his blindness where the program could yet be of value to him.

The other seven trainees were not actively engaged in efforts toward employment, although one was contemplating entering the vocational training program at Morgan Memorial.

It is difficult to see any connection between time lapse in employment and the trainees' ability to engage in some vocational planning, particularly when we see that both the trainees who had been unemployed longest and most recently were working toward a vocational goal.

Financial

At time of entering St. Paul's none of the trainees was actively employed, as previously stated. Three of the trainees were supported by either their parents or their wives. Seven trainees were receiving some form of Public Assistance or insurance.

At time of follow-up, one of the trainees previously supported by his wife, is employed and receiving some assistance from the Division of the Blind, so that his wife is no longer working (which was the goal of both of them). There is one other trainee being supported by his parents, who is awaiting approval to receive money from the Division of the Blind. There are no other changes in financial status. Perhaps four months is insufficient time to expect such changes to have taken place, when one realizes that the St. Paul's program is to prepare them to undertake vocational training, not to give them the vocational training.

Home and Child Care

At time of entering St. Paul's, six trainees had no responsibility for activity in the home and were permitted to do very little for themselves beyond a bare minimum of personal care. Of these six, two participated in decision making. Four of the trainees did have responsibility in the home and participated in activities and chores. Two of these four had children and participated in child rearing to some extent.

At time of follow-up, of the six who had no responsibility in the home either for themselves or for activities, two have made some improvement both in self-care and in participation in caring for the home.

The two who participated in decision making continued to do so, but have made no improvement in other areas of responsibility, one because of illness.

The extent of responsibilities of the other four both in home activities and decision making have all improved somewhat. In general six of the ten trainees made some improvement in this area.

Activities of Trainee

At time of entering St. Paul's, five of the trainees were almost completely housebound and rarely if ever, went out. Two went out occasionally with their wives, and three led rather active social lives both with family and with friends.

At time of follow-up, of the five who had been housebound,

two remain so. Of the other three, one is now in job training, but still does some writing for a hobby. He has no friends and is somewhat depressed about this because he feels his friends are either married or will have nothing to do with him because of his blindness. One has become friendly with a fellow trainee and visits him frequently out of town. When he is home, his way of life is unchanged. The third in this group now sits downstairs rather than upstairs, but does walk to the village center quite often, and attends a class in ballroom dancing with the encouragement of her counsellor from the Division of the Blind.

A trainee who slept during the day and went out with his wife in the evening, has been ill since training. However, for a short time prior to his illness and following St. Paul's, he did go bowling and shopping with the above-mentioned trainee who became his friend.

The other trainees continue to be active socially as before, but their activities are engaged in with more ease and enjoyment.

With the exception of the two trainees who do nothing, all other trainees have made some gains in social and general activities.

CHAPTER VII

RELATIONSHIP OF FAMILY ATTITUDES TO TRAINEE ADJUSTMENT

Having examined the families' attitudes both toward the trainee and toward St. Paul's, as well as the adjustment of the trainee following training, we shall now try to see what relationships can be found between the trainees' adjustment and these attitudes.

1. Relationship Between Family Attitude To Coming to St. Paul's and Trainee's Ability to Complete the Program

Eight of the ten trainees completed the training program. Of the two who left, one family did not want the trainee to come, one was mildly interested. Of the other eight, seven families wanted the trainee to come and one was mildly interested. The two who did not complete the program did not do so because of family attitudes. The eight who did had family support. One trainee left but returned because of family influence. In cases where there was some mixed feeling about being at St. Paul's, family attitudes were influential.

2. Relationship Between Family Attitude Toward St. Paul's and Change of Trainee Attitude toward Program

The trainees who did not want to come or who were mildly interested came from families who wanted the trainees to come. In all these cases the trainees attitude had

improved at follow-up. In this area certainly part of the change was due to the excellence of the program at St. Paul's, and to the attention paid to the trainees' problems in adjustment to the program.

It is interesting that in all cases it was found that at follow-up trainees' attitudes more closely approximated the families' attitudes toward St. Paul's at that time.

3. Relationship Between Family Attitude Toward Trainee At Follow-Up and Trainee's Use of Skills

TABLE 11

FAMILY ATTITUDE AT FOLLOW-UP AND TRAINEE USE OF SKILLS

Attitude	No	Use of Skills		
		T.D.L.* and Housekeeping	Mobility	Little Use of Skills in General
Supporting	6	4**	6	0
Hostile	3	0	2	1
Over-Protective	1	0	0	1
Total	10	4	8	2

*Techniques of daily living.

**One was too ill at follow-up to use many techniques but when well used his mobility; one has enough vision to manage without these skills.

The families considered supporting are those who encouraged independence in a positive way at time of follow-up. The three who were rated hostile, encouraged independence but in a negative way.

In general, three trainees were either working or engaged in efforts toward a vocational goal. A fourth trainee, a housewife, was using skills as intended, to maintain her home.

It would seem that in this area there is a definite connection to be seen between the families' supporting attitudes and the trainees' use of skills. Of the two trainees in the hostile group who used mobility, one used it because of his children; the other one used it because of self-confidence gained at St. Paul's and despite family attitudes. Her family is ashamed of the cane, and discourages her use of it in public.

It is interesting that at time of follow-up the family which was overprotective had not allowed the trainee to do anything beyond a minimum of personal care. In the families who encouraged independence in a hostile way, the trainees have made virtually no use of skills in the home. All of these families felt that the trainee had learned more than they were willing to use, but in no way spoke encouragingly to them about any attempts they made in the home to use skills learned.

One of the trainees has several young children and has made some attempt to take on responsibilities in the home, but his wife complained at follow-up that he is sloppy. In his presence, she devalued any efforts he has made in this direction. When he said that he occasionally tries to pour coffee, she said "Sure, and you spill it most of the time."

When he commented that he has diapered the baby, she told of the one time he stuck the baby with a pin. In spite of his wife's attitude, his 13 year old son has made efforts to renew his interest in power tools and frequently comes to him with questions about work he is doing with them. It would seem that any efforts he makes are clearly for the sake of the children, and with the encouragement of the son.

TABLE 12

VOCATIONAL ADJUSTMENT

Attitude of Fam. at follow-up	No.	Working	In trg.	Nothing	Other*
Supporting	6	1	1	3	1
Hostile	3		1	2	
Overprotective	1			1	
Total	10	2	2	4	

*She is a housewife actively engaged in homemaking, which was her goal.

In the overprotective group, the trainee left. The staff, however, even at admission, did not feel he would ever become gainfully employed, in spite of his great devotion to his 10 year old daughter and his desire to have money for her education. Staff reasons for this feeling are unclear.

In the one hostile family where trainee has made progress, this seemed to be clearly because of his children, and despite wife's hostile attitude.

In general, there seems to be little correlation between family attitudes and vocational achievements of the trainees. In the supporting group, other factors intervened. One trainee, from whom the staff had expected a great deal, was too ill at follow-up to be able to work although there were apparently jobs available for him. One trainee had been engaged in a mail order business with his wife's encouragement and active help. This business had failed some time before follow-up and trainee was naturally quite depressed. The third trainee was depressed by a broken engagement--the result of his blindness--and he felt he had no incentive for working.

4. Relationship Between Family Attitudes and Trainees Responsibility in the Home*

TABLE 13

RELATIONSHIP BETWEEN FAMILY ATTITUDES AND TRAINEE RESPONSIBILITY IN THE HOME

Family Attitude to Trainee	Number	Trainee											
		Activity in Home						Decision Making					
		Before			After			Before			After		
		M	S	L*	M	S	L	M	S	L	M	S	L
Overprotective--Remained so	1			1			1	1			1		
Overprotective--later encouraged indep.	3		1	2	1	1	1			3		2	1
Encouraged independence before and after	2	1	1		2			2			2		
Hostile before and after	3			3			3			3			3
Overprotective--unknown later	1			1	unknown			1			unknown		
Total	10	1	2	7	3	1	5	4		6	3	2	4

*M = much; S = some; L = little.

*This includes use of Housekeeping and Techniques of Daily Living skills in the home.

The trainee whose family was overprotective and remained so, did not change his status in any way. His family depended on him and still does, for making decisions, but allows him to do nothing in the home of a domestic nature. Since this is an Italian family, there may be some cultural reason for this beyond the trainee's blindness, for even in the other Italian family where they have encouraged trainee's independence, he is not allowed to take care of many of his needs. The role of the husband and father is decision making and not homemaking.

The trainees whose families were hostile both before and after training made no gains in the areas of activities in the home or decision making.

The trainees in the other two categories tended to maintain their previous level of responsibility or improve it.

It is interesting to note that in these areas involving functioning in the home, the attitudes of the overprotective and hostile families have the most marked effect.

In general, where attitudes of the families toward trainees' independence improved, the trainees' participation in the home activities also improved. Those trainees who had positive relationships with their families, with one exception, are more involved in family life. Those with family difficulties are not involved in family life, probably because it is in the home that the attitudes of the families have the most marked effect on their mood, motivation, and actions.

diabetes. However, at time of follow-up, only one trainee was so affected by his diabetes that he was unable to make great use of them.

They came to St. Paul's with few skills, little knowledge in the areas of braille, mobility, techniques of daily living. They hoped to make gains in these areas.

Regardless of family attitudes, more of the trainees did well in courses designed to increase basic independence such as mobility and techniques of daily living, than in the communications skills--braille and typing. At follow-up all but one trainee used mobility and all but two made use of some techniques of daily living. They were more interested in these courses during training and made more use of them at follow-up.

Also, regardless of family attitudes, none of the trainees used braille after training, and few made any use of typing. Two of the three trainees who were using it at follow-up had used it before training.

In the area of vocational gains, three trainees were either working or in training, which also had little to do with family attitudes.

However, in the area of responsibility in the home there was a high correlation between family attitude and trainee functioning. Trainees who had good relationships with their families were able to use their skills at home and participate in decision making. Those in whose homes there was some discord did not use their housekeeping skills or many of their techniques of daily living of use

in the home. They also participated little in decision making.

Their ability to remain through the program was also seen to be at least partly affected by family attitudes. It is also interesting when one considers the rigorous nature of the program, and the contrast of this to the inactivity from which most of them came, that only two of the trainees left before the end of training. This is really quite remarkable and speaks well for the supportive help given them as well as the determination sparked in them by the program.

In general the total St. Paul's experience seemed to be a positive one for the trainees. It seemed both from the point of view of the families and the trainees that the separation was a therapeutic experience. Many of them had wanted the separation and those who did, felt they gained by it. For the families who had been overprotective it was a chance to see these trainees develop and perform tasks they had not thought possible. This helped toward permitting them greater independence. For the trainees it was an opportunity to be separated from families who were either depressed about this blind member or angry at him. It was also an opportunity for the trainees to be separated from the general community and to try to come to terms with their blindness among people who did not see them as odd.

In spite of the small sample, there was evidence that some further help with families would be helpful to both the trainee and his family. The findings show that in those families where there were problems in interpersonal

relationships, the blindness caused an exacerbation of the problem, and some help in dealing with the family around the problem itself would help the trainee, indirectly, to be able to use his training in a more effective way.

The families with no problems in interpersonal relationships were more supporting and encouraged trainees efforts toward further independence.

Although things turned out better for these trainees, these families expressed a desire for further help, both at the Family Conference and at follow-up. The rehabilitation effort is focused largely around the trainee and his needs and perhaps more attention could be given to the difficulties that even these more supporting families have in managing with a blind family member. They also have problems and needs for which they could well use further help and support. This is probably not as urgent as for those families with problems in relationships, but the area seems deserving of further attention.

It is hoped that further study of the affects of blindness on family relationships and on use of rehabilitation training by the trainee, might be done to learn in which areas, and what type of help would be of most benefit.

APPENDIX A

SCHEDULE

CASE NUMBER _____

I. IDENTIFYING DATA

A. SEX _____ B. DATE OF BIRTH _____

C. MARITAL STATUS: Married ___ Single ___ Widowed ___
Divorced ___ Separated ___

D. FAMILY CONFIGURATION IN HOUSEHOLD

	SEX	AGE	RELATIONSHIP TO TRAINEE	OCCUPATION
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

E. RELIGION _____

F. EDUCATION:

1. Completed grammar school ___ some high school ___
Completed high school ___ some college ___
Completed college ___

2. Special Vocational Training (Specify) _____

_____

II. ADVENT OF BLINDNESS

A. STATUS

1. Cause of blindness _____

2. Degree of residual vision _____

3. Prognosis _____

B. ONSET AND DURATION _____

1. Onset of loss of vision (Describe briefly) _____

_____

_____

2. Date legally blind _____

C. PHYSICAL DISABILITIES

1. Related to blindness _____

_____

2. Unrelated to blindness _____

_____

_____

III. STAFF ASSESSMENT AFTER ST. PAUL'S

A. STATUS

1. Physical _____

_____

2. Mental _____

3. Emotional _____

_____

B. ACHIEVEMENT OF SKILLS

1. Braille _____

2. Housekeeping _____

3. Mobility _____

4. Techniques of Daily Living _____

5. Shop _____

6. Sensory Training _____

7. Typing _____

8. Fencing _____

9. Spoken Communication _____

IV. PATIENT'S FUNCTIONING AT TIME OF ENTERING ST. PAUL'S

A. WORK

1. Type of Work _____

2. Status of employment

a. Last date of employment _____

b. Reason for unemployment _____

c. Stability of employment _____

_____

_____

_____

B. SOCIAL ADJUSTMENT

1. Friendship Relationships
Describe briefly character and extent

a. Number _____

b. Sex _____

c. Activities _____

_____

2. Formal Organized Activities (Describe briefly)

a. Church _____

b. Sports _____

c. Entertainment _____

d. Other (Specify)_____

3. Activities engaged in along _____

_____

4. Interest in Current Happenings (Describe) _____

_____

a. Source of information: Paper ___ Radio ___ TV__

Other (specify) _____

C. RELATION WITH FAMILY

1. Financial Responsibility

a. Sole support _____

b. Partial support (explain) _____

c. Non-contributing _____

d. Support from Division of Blind (specify) ___

_____

2. Responsibility for Family Life

a. Decision Making _____

b. Activities with children _____

c. Responsibility for care of other members of the family _____

3. Emotional Climate of the family

a. Describe general affective character of family

_____

_____

_____

b. Describe specifically relation of family to trainee _____

_____

4. Family's Response to Blindness

a. Describe briefly any particular reactions noted (i.e., guilt, shame, anger, despair, God's will, etc.)

_____

_____

b. Appraisal of trainee's capabilities (include here magical thinking, blind stereotypes, possibilities for future independent life) _____

_____

_____

c. Describe briefly attitude toward trainee's entering St. Paul's _____

_____

_____

D. TRAINEE'S ADJUSTMENT TO BLINDNESS

1. Feelings about prognosis of regaining sight (describe) _____

_____

2. Feelings about loss of sight _____

_____

_____

_____

3. Attitude toward coming to St. Paul's (describe)

_____

_____

_____

E. DEGREE OF INDEPENDENCE OF SELF-CARE

1. Personal Hygiene

a. Diabetic _____

(1) Insulin _____ (2) Urine Testing _____

(3) Other (Specify) _____

b. Non-diabetic _____

(1) Personal hygiene needs not met by trainee himself _____

2. Activities of Daily Living (Describe briefly)

a. Eating _____

b. Cooking _____

c. Dressing _____

d. Shopping _____

e. Cane travel _____

f. Other (specify) _____

g. Communications ability (braille, typing, etc. Specify) _____

V. ADJUSTMENT OF TRAINEE AT TIME OF FOLLOW-UP

A. WORK

1. Present Employment

a. Relation, if any, to past employment _____

_____

b. List use, in job, of training skills gained at St. Paul's _____

_____

c. Satisfaction with employment (specify) _____

_____

d. Earnings relative to earnings before blindness

_____

2. If not presently employed, explain _____

_____

_____

_____

B. SOCIAL ADJUSTMENT

1. Friendship relations
Describe briefly character and extent

a. Number _____

b. Sex _____

c. Activities _____

2. Formal Organized Activities (Describe briefly)

a. Church _____

b. Sports _____

c. Entertainment _____

d. Other (specify) _____

3. Activities engaged in alone _____

4. Interest in current happenings (Describe) _____

_____

a. Source of information: Paper ____ Radio ____

TV ____ Other (specify) _____

C. RELATION WITH FAMILY

1. Financial Responsibility

a. Sole support _____

b. Partial support (explain) _____

c. Non-contributing _____

d. Support from Division of the Blind or other Government agency (Specify) _____

_____

2. Responsibility for Family Life

a. Decision Making _____

b. Activities with Children _____

c. Other responsibilities within family _____

_____

3. Emotional Climate of Family

a. Describe general affective character of family

_____

_____

b. Describe specifically relation of family to trainee _____

_____

4. Family's response to St. Paul's (Describe) _____

_____

_____

_____

D. USE OF TRAINING SKILLS.

1. Use of Mobility Training

a. Aids in mobility (describe briefly)

(1) Cane _____

(2) Dog _____

(3) Guide _____

b. Travel (describe briefly)

(1) Alone or with others _____

(2) Frequency _____

(3) Purposes _____

_____

2. Use of braille

a. Reading _____

b. Corresponding _____

c. Labelling _____

d. Other (specify) _____

e. None _____

3. Use of typing

a. Typewriter available _____

b. Frequency _____

c. Purpose _____

4. Use of housekeeping skills

a. Skills used _____

b. Frequency _____

c. Purpose _____

5. Techniques of Daily Living Skills

a. Skills used _____

b. Frequency _____

6. Orientation to Surroundings (describe briefly)

a. Surroundings in house _____

b. Neighborhood _____

c. Facing people in conversation _____

_____

7. Personal Hygiene and Self-Care

a. Diabetic ____Non-Diabetic ____

b. If diabetic, state degree of self-care with diabetic needs _____

_____

c. If non-diabetic, persoanl hygiene needs not met by trainee himself _____

_____

d. Grooming

(1) Appropriate clothing _____

(2) Describe general appearance _____

_____

E. ATTITUDE AND STATE AND MIND

1. Sleep Habits (describe briefly) _____

_____

2. Appetite (describe briefly) _____

_____

3. Concern about future (describe briefly) _____

_____

4. Concern over personal health (describe briefly)

_____

5. Recommendations made by St. Paul's

Recommendations _____Carried out _____

Not (explain) _____

_____

_____

_____

6. Contact with St. Paul's since end of Training period (describe briefly) _____

_____

_____

7. Trainee's concept of family attitude toward him since training (describe briefly) _____

_____

_____

a. Family actions which have inhibited him ____

_____

_____

_____

b. Family's attitudes and actions which have encouraged him _____

_____

_____

8. Trainee's Attitude toward St. Paul's (describe)

_____

_____

_____

VI. FAMILY'S VIEWS AND REACTIONS TO BLINDNESS

A. POSITIVE (Describe briefly)

1. Supportive feelings _____

_____

2. Realistic appraisal of abilities _____

_____

3. Helpfulness _____

_____

4. Acceptance of limitations _____

_____

B. NEGATIVE (Describe briefly)

1. Futility regarding future _____

_____

2. Unrealistic expectations _____

_____

3. Stereotypes about the blind _____

_____

4. Describe briefly feelings of guilt, anger, shame, pity, etc. noted by interviewer _____

_____

_____

_____

C. FAMILY'S ATTITUDE TOWARD ST. PAUL'S (Describe briefly)

_____

_____

VII. BEHAVIOR OF FAMILY WITH TRAINEE

A. If trainee is father or husband, describe briefly role he has been allowed to resume and how it is handled.

1. Discipline _____

2. Decision making _____

3. Assumption of feminine role while wife works ___

_____

B. Responsibility given to trainee (describe briefly) __

_____

C. Degree of encouragement to follow regular family schedule of rising, eating, etc. (Describe briefly) ____

_____

_____

D. Outside Activities with Trainee

1. Visits to restaurants and other public places.

a. Extent to which he is encouraged to use mobility techniques _____

_____

2. Degree of encouragement to go out alone, and attitude toward this (describe briefly) _____

_____

_____

E. Household activities

1. Help given trainee

a. Cutting good _____

b. Choosing clothes _____

c. General activities _____

2. Encouragement to braille labels for frequently used items _____

F. General Activities Encouraged or Discouraged (Describe briefly) _____

_____

G. Behavior at Interview

1. Describe briefly the following:

a. Who opened door _____

b. Who took Interviewer's coat _____

c. Refreshments served _____by whom _____

_____

d. Who handled activity around interview _____

_____

e. General atmosphere _____

_____

f. Use of broadcast voice: by trainee _____

by family _____

2. Interviewer's assessment _____

_____

_____

_____

_____

VIII. PARTICIPATION IN FAMILY CONFERENCE

A. MEMBERS WHO ATTENDED

1. _____

2. _____

3. _____

B. PARTICIPATION (Describe briefly)

_____

_____

_____

Date of Interview: _____

Family Member Interviewed _____

ADDITIONAL NOTES

APPENDIX B

DEFINITIONS

STAFF IMPRESSIONS: Result of differing impressions made by him on staff at time of entrance, during course, and at end. These observations were brought out and discussed at special staff conferences about each trainee. Committee of four then formulated various impressions into composite picture.

HOUSEKEEPING: This course is designed to help the blinded person meet the normal situations which arise around the home, particularly the kitchen. In many ways, this course has the same objectives as the Shop courses.

TECHNIQUES OF DAILY LIVING (PRINCIPLES): This is one part of a two-fold course which is concerned with handling the hundreds of small (by themselves) problems which arise in the course of the everyday life of a blind person. This section deals with the ease of meeting constantly arising situations and putting sighted people at ease.

TYPEWRITING: The aim of this course is to restore the capacity for written communication. The necessary skills are taught so that the typewriter can be used as a tool of personal expression in both letter writing and manuscript work.

SPOKEN COMMUNICATION: The aim of this course is to assist trainees to communicate orally with effectiveness. It proposes to help the blinded person handle himself with ease in conversation with others.

TECHNIQUES OF DAILY LIVING--DRILLS: This is one part of a two-part course which is concerned with handling of hundreds of small (by themselves) problems which arise in the course of the everyday life of a blind person. This section consists of drills and practices in skills and devices.

BRAILLE: Braille is taught to acquaint the trainee with a means of restoring the loss of communication, using Grade II Braille. The slate and stylus and the mechanical brailler are used to find practical uses for braille suited to individual needs and preferences.

FENCING: This is a course for sense development, physical education in posture, poise, rapid muscle memory response, discrimination and localization of sound cues and--

particularly to the use of the long cane--ready wrist motion, skill in handling a tool which extends the sense of touch, and immediate response to information gathered through it.

SENSORY TRAINING: This course aims for increased sensory intake by specific training which accentuates awareness of the environment. It involves sensory reorganization for efficient use of improved sensory intake which assists mobility. Procedures, drills, techniques and exercises are continually being devised; existing knowledge in appropriate fields is being exploited and research encouraged.

MOBILITY: A course designed to teach blind persons to become independent travelers through the use of the remaining senses and the Hoover cane technique.

ATTITUDES AND ANALYSIS: One of the basic courses at St. Paul's, this is designed to help the trainee understand his blindness better, its meaning, its effects on skills and attitudes. Its purpose is to assist him to know and to face the problems involved, and then to give him the information concerning what he can do about it. This is primarily a lecture course, involving some participating and discussion.

GROUP THERAPY: The trainees meet twice a week for an hour each time. The purpose of the meeting is to provide an opportunity for expression of real feelings, attitudes and opinions in a permissive setting, where the role of the group leader is to clarify the meaning of the particular situations which arise.

SHOP GROUP: A project type course seeking the objectives of shop, and providing an opportunity for observations of functioning in a group situation.

SHOP: A course designed, among other things, to restore the blind person to his role in the home, to overcome fears through the use of hand and power tools; to stimulate confidence in the other senses and encourage orderliness, which is transferable to other situations.

SPATIAL ORIENTATION: In this course, the structure and functions of all external and internal sense organs used in orientation are described, and demonstrations of possibilities and limitations of each given. The sensory intake from these is correlated in exercises with a technique of quick mental mapping and visualizing of one's environment and to enable the trainee to "navigate" well. The individual trainee's particular sense abilities and limitations are tested and the techniques of sense-use are adjusted to his needs.

IMAGERY STIMULATION: An experimental course in the stimulation of visual imagery through manipulative exercises in form and color.

THE ART OF VISUALIZATION: The vast store of visual images in the blinded adult's memory is made use of in this course by training the mind's eye to respond vividly, accurately and continuously to all sense stimuli coming from one's environment. The special technique involved is to concentrate on the sensory intake from the area toward which one's head is turned, thus making the picture evoked in the mind's eye correspond as fully and accurately as possible with what one would normally see with his eyes.

GROUP VOCATIONAL COUNSELING: This is a group meeting designed to promote a close cooperative relationship between the role of the vocational counselor and the trainee. It is also intended to develop on the part of the trainee an understanding of some of the problems attendant upon employment as a blind person. An effort is made to develop an awareness of the factors that promote, as well as those that deter, the development and maintenance of a satisfactory employment situation.

There is also a GRIPE SESSION and one group of four lectures on SOCIAL SECURITY STATUS, both of which are self-explanatory.

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